ASPSNEWS

AMERICAN SOCIETY OF PLASTIC SURGICAL NURSES, INC. AUGUST 2009

From the Boardroom...

In 2003, Blackie Scott, author and humorist, gave the keynote address to our members at the ASPSN 29th Annual Convention in San Diego, CA. At that time, she suggested a goal for us as plastic surgery nurses to better know and embrace the concept that our lives are more than "skin deep." With our work and community responsibilities, home life, marriages, relationships, and kids, we lead very busy lives. We are experienced professionals, but sometimes the lines become blurred as we are trying to "do it all." We need to do as Blackie has recommended: give balance to our lives, enjoy the diversity of our friendships, and value family time. If we can relieve our stresses, we will become more positive. I feel the goal of each one of us is to make a difference in someone's life, right? With our positions at work and in our homes, we have that opportunity on a daily basis.

Just remember; take time for yourself. If you take care of yourself, you will be more productive, provide better care to your plastic surgery patients, and enrich the lives of those around you. Enjoy what you have. As we have seen recently, life is way too short; we can not take anything, anyone, or any moment for granted. We are a special group of nurses and caregivers to our patients that have, often times, undergone life altering events. When you have embraced the concept that our lives are more than skin deep, you will be able to make a difference in your patient's life.

Sharon Fritzsche
ASPSN President-Elect

Aesthetic Lines

Marilyn Cassetta, RN, BScN, CPSN

A specialty biopharmaceutical company from northern California, Revance Therapeutics, seems to have cracked the code in creating a new drug delivery system, Trans*MTS,* which allows the delivery of macromolecules across the skin.

Just when you thought you had your Botulinum Toxin Type A injection skills perfected, their lead investigational product, RT001, is a physician-applied ***topical gel*** Botulinum Toxin Type A product for cosmetic, hyperhdrosis, and other dermatologic indications. They are also busy developing a *next generation* injectable Botulinum Toxin Type A, the goal being an improvement to the onset of action, increase the duration of action, and eliminate the need for human and animal components.

Clinical studies currently underway, both in the U.S. and internationally, have demonstrated the efficacy of RT001, and it has been safe and well-tolerated. A principal investigator of the study, Dr. Richard Glogau, Clinical Professor of Dermatology at the University of California, San Francisco, states, "The benefits of RT001 are clear; patients achieve meaningful clinical results with a simple, painless procedure." The End of Phase 2 studies will be followed by a meeting with the FDA, later this year. It is believed that by offering a safe, efficacious, and painless procedure, it will have an even wider appeal to consumers who have been either uncomfortable with needles or with the pain and bruising often associated with injectable procedures.

What will they think of next?

http://www.revance.com/

Topically Applied Botulinum Toxin Type A for the Treatment of Primary Axillary Hyperhidrosis: Results of a Randomized, Blinded, Vehicle-Controlled Study

A Phase 1, Randomized, Placebo-Controlled, Safety and Efficacy Study of a Botulinum Toxin Type A Topical Gel for Treatment of Lateral Canthal Lines

Marilyn Cassetta, RN, BScN, CPSN is an independent contractor/ Aesthetic Nurse Specialist since 1986, and has lived in Sydney, Australia since 1992. Marilyn is currently a Board Member of ASPSN.

Editorial

Haley Wood, MSN, WHNP
ASPSN Newsletter Editor

It's always exciting to introduce a new column to the newsletter! "Learning with Miss Adventures" is a fictional column based on plastic surgery scenarios with an educational twist. The debut column discusses a case involving throat packs. When I read the column, it brought back a vivid memory I have of recovering a physical handicapped patient after surgery. The patient's oxygen levels quickly declined in the recovery room. As we were attempting reintubation, a throat pack was discovered. Although this new column is fictional, the situation can be real, as in my case.

Susan Kunz has also written a fabulous article on student nurses in outpatient surgery facilities. A few editorials ago, I wrote about the great need for mentors in nursing. This article is an objective illustration of how we "eat our young."

If you have an interesting case study or patient scenario, share it with us! We are always looking for contributions from our members to enhance not only our newsletter but also add to our knowledge! Don't hesitate to submit and share a clinical pearl or other quick fact that helps your work day run smoother! We are anxious to hear and learn!

As I study for the CPSN exam, I feel the calling to add more trivia tidbits to the newsletter! If the word scramble didn't scramble your brain, maybe these questions will.

Testing: ONE, TWO, THREE!

1. An abnormal increase in the bony distance between the medial orbital walls is called
- A. Ptosis
- B. Microtia
- C. Hypotelorism
- D. Hypertelorism

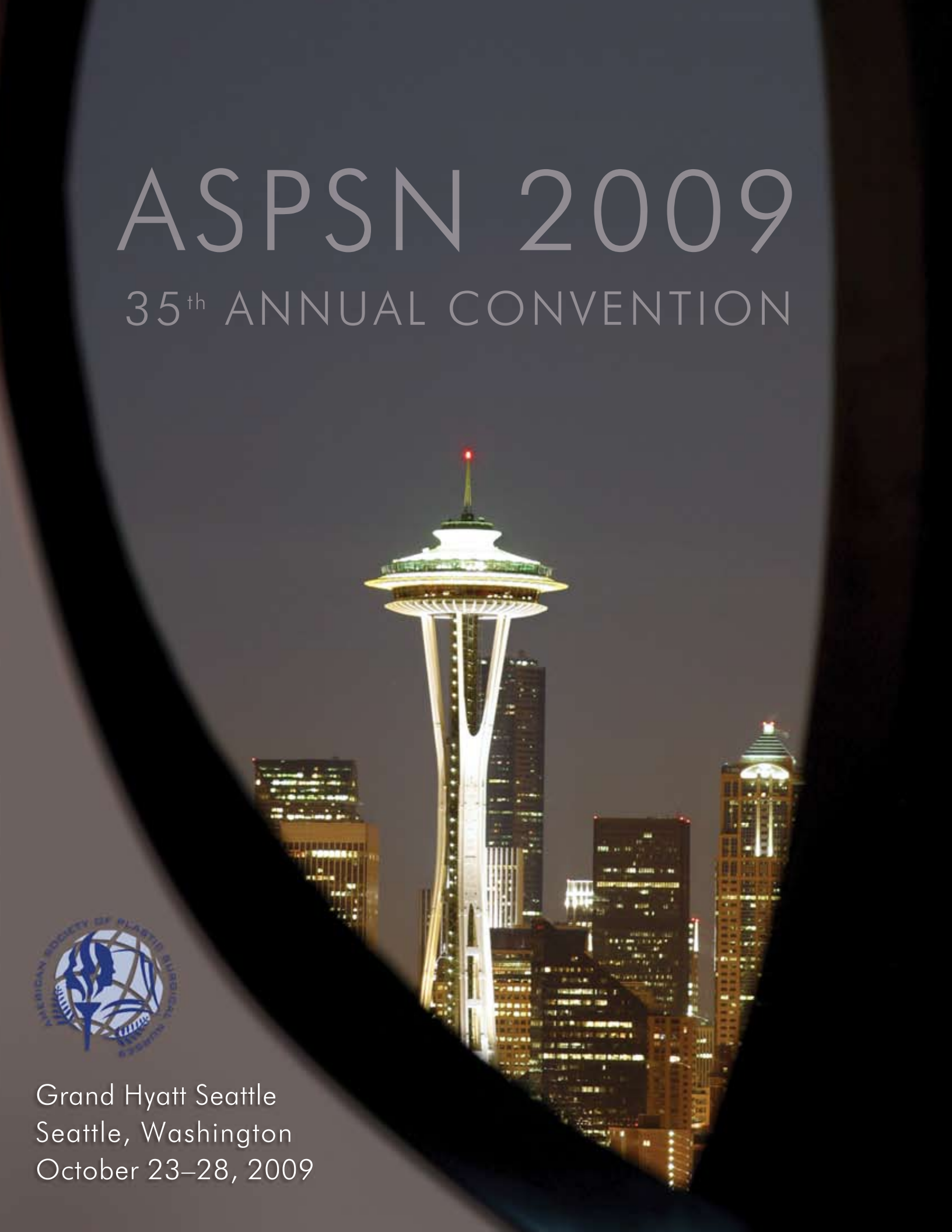
2. Preoperative evaluation of bone/joint injury in the hand involves
- A. Pinprick test
- B. Pinpoint tenderness to palpation
- C. Assessment of apposition of thumb to little finger
- D. Electromyography/nerve conduction studies.

3. Aspirin-containing compounds are implicated in which of the following situations?
- A. Excessive scar formation resulting in poor outcomes.
- B. Vasoconstriction and poor tissue perfusion resulting in delayed healing.
- C. Alteration in clotting mechanism causing the potential for excessive bleeding
- D. All of the above

Answers on page 8

ASPSN 2009

35th ANNUAL CONVENTION



Grand Hyatt Seattle
Seattle, Washington
October 23–28, 2009

2009 Scientific Sessions Update

Georgia Elmassian, BAS, RN, CPSN
Scientific Sessions Chair

The ASPSN National Convention is two months away. With that in mind, we would like to take this opportunity to remind members of all the wonderful activities Seattle has to offer. Scientific Sessions Planning Committee member Amanda Bailey, ACNP has diligently researched Seattle's October event happenings and has compiled a short list of opportunities for your perusal and planning.

THEATRE

5th Avenue – *Joseph and the Amazing Technicolor Dreamcoat*
Friday, October 23, 8pm; Saturday, October 24, 8pm; Sunday, October 25, 7pm; Tuesday, October 27, 7:30pm

Tue/ Sun Evening:

Group Size:	10-20	21-75	76+	Full Price
Pearl Section	N/A	N/A	N/A	$88.00
Orchestra/Grand Tier	$70.25	$62.75	$55.25	$78.00
Back Orchestra	$61.25	$54.75	$48.25	$68.00
Middle Balcony	$61.25	$54.75	$48.25	$68.00
Upper Balcony	$41.50	$37.25	$32.75	$46.00
Side Balcony*	$25.00	$25.00	$25.00	$25.00

Friday/Saturday* Evening:

Group Size:	10-20	21-75	76+	Full Price
Pearl Section	N/A	N/A	N/A	$93.00
Orchestra/Grand Tier	$74.75	$66.75	$58.75	$83.00
Back Orchestra	$65.75	$58.75	$51.75	$73.00
Middle Balcony	$65.75	$58.75	$51.75	$73.00
Upper Balcony	$45.25	$40.50	$35.75	$50.00
Side Balcony*	$29.00	$29.00	$29.00	$29.00

Prices **include** a $2.50 per ticket facility fee. A single $10.00 handling fee will be applied to a group order.
*No group discount for Saturday evenings or side balcony.

PLACES OF INTEREST

The Duck – Tour of Seattle by land and by sea on an amphibious vehicle. For groups of 10 or more, tickets are $22.50. The "duck" departs every ½ hour from the Space Needle 9am-5pm 7 days a week. With an additional $2 you get a noise maker, and for $13.95 more you get a boxed lunch.

The Space Needle – There are two options . . . the restaurant or just sightseeing. They are open for brunch on Saturday and Sunday 10am-2:45pm; for lunch M-F 11:30-2pm; dinner Sunday-Thursday 5pm- 8:45pm; with dinner Friday and Saturday 5pm-9:45pm. Reservations required.

The observation deck and retail store are open all week from 9am-11pm. Tickets for the observation deck are $16 for adults. Or by paying $21.00, you can visit twice in a 24 hour period i.e., once during the day time and once at night.

Pike Place Market – This is a large open air market with many restaurants for breakfast, brunch, lunch and dinner. One would have to check out the individual places because they are too numerous to list here.

Amanda also gathered Ghost Tour information for the convention attendees to explore.

(continued on page 6)

2009 Scientific Sessions Update *(continued from page 5)*

GHOST TOURS

Private Eye Tours - This company offers (3 Options) with complimentary pick up at your hotel for out of town visitors. These are all highly rated. http://www.privateeyetours.com

Option 1 - *Queen Anne Mystery & Murder Tour* - This is 2.5 hours long with minimal walking. This tour covers several topics including mass murder, tong wars, a million dollar burglary, brothels, arson, hatchet man, soy sauce murder mystery, blue eyes, and death by cyanide; $25/person.

Option 2 - *Capitol Hill Mystery and Murder Tour* - This is 2.5 hours long also with same minimal walking notation. This tour covers several topics including was it suicide (the kid from Aberdeen), the reservoir man, the great "Raoul", chicken legs, goldmarks, the congressman, Mr. Tommy gun, the mystic reverend, Jimi Hendrix, Bruce Lee, and Ted Bundy. $25/person.

Option 3 - *Haunted Happenings: A Seattle Ghost Tour* - This is 3 hours long visiting several locations including an elegant hotel, a mortuary, the market, a gambling den, poor farm, the voice, the castle, old burial ground, the basketball player, haunted theater, notorious rooming house and much, much more; $25/person.

OTHER GHOST TOURS

Market Ghost Tours - This is a 1 hour walking tour through Pike Place Market. $15/person. The 5pm tour is heavily history based while the 7pm and 9pm tours are more "ghostly." Tours are only Wednesday-Sunday (no tours Monday and Tuesday). Group rates are available, but prices are based on the number of people that sign up. http://www.seattleghost.com

Spooked in Seattle - Another walking tour down by the waterfront and parts of Belltown and the Pike Place Market. Fridays and Saturdays at 6pm. Arrangements can be made for private group tours. $15/person; does not state the time length of the tour. http://www.spookedinseattle.com

Additionally, for those attending the convention and who like to "plan in advance," Lisa Machak RN, of the Western Washington Chapter has generously assembled a list of her chapter's favorite Seattle restaurants for you to scan and perhaps call ahead for reserved seating. She has also included a pricing guide for your convenience.

SEATTLE RESTAURANTS:

1.) Space Needle $$$$
2.) Waterfront Seafood Grill $$$$
3.) El Gaucho $$$$
4.) Metropolitan Grill $$$$
5.) Salty's $$$$
6.) Ray's Boat House $$$
7.) Anthony's Homeport $$$
8.) Elliot's On the Waterfront $$$
9.) Ivar's $$$
10.) Matt's in the Market $$
11.) Ponti Seafood Grill $$
12.) Purple Café and Wine Bar $$
13.) Steelhead Diner $$
14.) The Pink Door $$
15.) Tulio Ristorante $$

This is just a very small sampling of eateries available in Seattle. Lisa suggests looking up restaurant reviews at www.seattletimes.com. Here you will find restaurants that are indexed by price range, best reviewed, and geographical subsections of the city.

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Portfolios for Practice

Marcia E. Spear, ACNP-BC, CWS, CPSN
Regional Director

What is a portfolio? According to Scholes and colleagues (2003), a portfolio is a purposeful collection of evidence to demonstrate personal and professional growth. A portfolio can also take on the form of a personal collection of evidence which demonstrates a professional's obligation to life-long learning (Scholes et al., 2003). Critical thinking and reflective writing are seen as crucial elements. Many formal educational programs are incorporating the portfolio as a means to assess learning and mastery of skills.

A portfolio provides a collection of detailed evidence of a person's competence (Scholes et al., 2003). The Royal College of Nursing (2005) has developed competencies for nurses to practice aesthetic medicine. In addition to identifying core competencies for practice, professional accountability and evidence to demonstrate competence are also discussed. This document emphasizes personal responsibility for developing a portfolio of evidence, which would demonstrate the competency was achieved and the individual is competent for practice. What constitutes evidence? Projects, reflective diaries, publications, presentations, teaching materials, policy and procedure development, research, certification and continuing education are all considered evidence and should be included in a portfolio. Bancroft and colleagues (2008) discussed the core competencies in plastic surgery and suggest a portfolio as a mechanism to evaluate education, training and the performance of plastic surgery residents.

A portfolio can be useful to assess and maintain competence for practice. Continuing education alone may not be enough to assure competence. There are many types of evidence to be included in a portfolio, and one would think that having diversity would be more desirable. As nurses, growing professionally is an individual responsibility and should be taken seriously. After all, a portfolio may add a little fun to the process.

Bancroft, G., Basu, C., Leong, M., Mateo, C., Hollier, L & Stal, S. (2008). Outcome based residency education: teaching and evaluating the core competencies in plastic surgery. *Plastic and Reconstructive Surgery.* 121(6), 441e-448e.

Royal College of Nursing (2005). Competencies: an integrated career and competency framework for nurses in aesthetic medicine. London: WIG ORN

Scholes, J., Webb., C., Gray, M., Endacott, R., Miller, C., Jasper, M. & McMullan, M. (2003). Making portfolios work in practice. *Journal of Advanced Nursing.* 46(6), 595-603.

What Do *You* Think?

Sue Kunz, BS, RN, CPSN
Regional Director

Outpatient Surgery Weekly E-News recently reported on a survey regarding nursing students in outpatient surgery facilities. The InstaPoll question put forward, "Do you let nursing students do rotations or training at your facility?" I was shocked and disappointed in the response; 54% of the 24 facility managers answered, "the operating room is no place for nursing students." I am still shaking my head! How is one to learn about the OR? What a wonderful opportunity to introduce young, eager, interested potential OR nurses of the future to a field of nursing that has been all but forgotten in many nursing school programs. I have practiced in University Hospitals, community hospitals, and am presently in a private practice with a surgical suite. In all of these settings, we have allowed and welcomed nursing students in the operating room. What better way to spark an interest in working as a surgical nurse than allowing students into the operating room. If we do not take that step, who will? Who will we employ in the OR when the aging nursing population presently working in the OR retires?

I would like to take this opportunity to pose the same question to our society: **Do you let nursing students do rotations or training at your facility?** I would encourage a dialog along with a yes/no answer. Why or why not?

Learning with Miss Adventures

Dear Miss Adventures,
Recently a new surgeon at our facility asked to change the process and documentation on the insertion of our throat packs. He said he once saw a throat pack left in an awake, extubated patient. Is this possible?
Your loyal reader

Dear Loyal Reader,

Miss Adventure agrees with your new surgeon that there are never too many safety measures if there is a chance of a retained object. Remember, retained objects are considered"never events" by the Joint Commission. The documentation and accountability of pharyngeal packs varies by institutional policy and that is probably why your new surgeon has a different approach to it. Let's examine the use of pharyngeal packs.

Phayngeal packs, also known as throat packs, are inserted for surgical procedures involving the face and mouth. They serve several purposes. They are a physical barrier that prevents fluids such as blood and irrigation from entering the lung resulting in an aspiration pneumonia. They prevent these same fluids from entering the stomach and resulting in increased possibility of post operative nausea and vomiting. The pack acts as a barrier for the surgical team as well, preventing the escape of anesthetic gases to the surgical field. This is especially significant in pediatric surgery, when the ET tube cuff is intentionally left to "leak." The leak around the ET tube ensures that the inflated balloon (used to secure the tube below the vocal cords), does not cause erosion of the trachea. A properly inserted pharyngeal pack is beneficial to both the patient and the surgical team.

Pharyngeal packs come in many shapes and sizes and so do patients. Depending on institutional policy, packs may be identified with radiopague markers, suture tags, surgical instruments and may or may not be cut for proper fit. A bulky pharyngeal pack can obstruct the surgical field if it's an intraoral approach. Institutional consistency is the key to the safe insertion, removal and documentation of the pack. It is suggested that the documentation of the pharyngeal pack be reflective of the intentional insertion after intubation and the intentional removal before extubation. The actual pharyngeal pack should be visible to the surgical staff before it is inserted, it should be noted aloud and in writing whether or not it had to be cut for insertion and it should be visible upon removal, acknowledged that it was removed by the surgeons, the nursing staff and the anesthesia team and documented accordingly. If the pack was cut, both pieces of the pack should be visible.

Is it possible to leave a pharyngeal pack in after a patient is awake and extubated? Actually, consider this case study. The resident oral surgeon inserts the throat pack and calls out to the team that the pack has been inserted. He then cuts the extruding portion of the pack and leaves that portion in the bowl on the prep table. As he leaves to go to the scrub sink, the attending surgeon enters the room. Seeing the throat pack in the bowl, he inserts it. The surgeon also calls out that the throat pack has been inserted and the team agrees, as it surely had been! At the end of the case, the pack is removed, although it is actually two packs that have been placed. The inexperienced nursing team, is not aware that the pack has been cut and believes that the pack has been removed in its entirety. At this point, the initial throat pack has been dislodged and pushed into the patient's stomach. The patient awakens, is extubated and moved to the PACU. After a short while, the patient vomits in the PACU and the second piece of the throat pack is expelled. It happens!

Strong policy, consistent practice, verbal communication, and education are all key factors in prevention of retained objects, including pharyngeal packs. Remember Murphy's Law and count, count. and count again!

Sincerely,

Miss Adventures

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If you would like information on starting a local ASPSN chapter, please contact Richelle Torres, Chapter Services Specialist at richelle.torres@dancyamc.com

Answers to Testing: ONE, TWO, THREE 1. D 2. B 3. C